



Reprinted
April 6, 2001

ENGROSSED HOUSE BILL No. 1866

DIGEST OF HB 1866 (Updated April 5, 2001 3:22 PM - DI 98)

Citations Affected: IC 12-15; noncode.

Synopsis: Medicaid. Allows the Medicaid drug utilization review (DUR) board to meet monthly. Requires the DUR board to make recommendations to the office of Medicaid policy and planning (OMPP) on disease management programs for Medicaid recipients with asthma, diabetes, congestive heart failure, or HIV/AIDS. Requires the DUR board to submit its recommendations to OMPP and the health finance commission by September 30, 2001. Requires OMPP to provide information to the DUR board that is necessary for the board to carry out its advisory capacity. Requires the office of the secretary of family and social services (FSSA) to make various amendments to the administrative rule regarding the Medicaid case mix reimbursement system for nursing homes, including separating the cost of professional liability insurance from the administrative rate component. Requires OMPP to apply to the federal Health Care Financing Administration (HCFA) for a Medicaid state plan amendment to implement certain rule changes. Prohibits FSSA from repealing or amending certain administrative rules without statutory authority. Requires FSSA, not
(Continued next page)

Effective: Upon passage.

Crawford, Porter, Friend, Crosby

(SENATE SPONSORS — MILLER, SIMPSON)

January 17, 2001, read first time and referred to Committee on Ways and Means.
February 26, 2001, amended, reported — Do Pass.
March 5, 2001, read second time, amended, ordered engrossed.
March 6, 2001, engrossed. Read third time, passed. Yeas 63, nays 32.

SENATE ACTION

March 15, 2001, read first time and referred to Committee on Finance.
March 29, 2001, amended, reported favorably — Do Pass.
April 5, 2001, read second time, amended, ordered engrossed.

EH 1866—LS 7910/DI 98+



C
o
p
y

later than August 1, 2001, to evaluate certain information regarding health care costs, develop Medicaid programs or funding mechanisms, and submit a state plan amendment to HCFA for approval of those programs or mechanisms. Requires FSSA to file a report with the legislative council regarding the development of programs or funding mechanisms by October 1, 2001. Requires OMPP to contract with an outside individual or entity to develop: (1) a disease management program for Medicaid recipients in certain counties who have asthma, diabetes, congestive heart failure, or HIV/AIDS; and (2) a case management program for Medicaid recipients in certain counties whose per recipient Medicaid cost is in the highest 10% of specified recipients. Requires OMPP to report to the legislative council regarding the development of the disease management and case management programs by December 31, 2002.

C
o
p
y



Reprinted
April 6, 2001

First Regular Session 112th General Assembly (2001)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2000 General Assembly.

ENGROSSED HOUSE BILL No. 1866

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Be it enacted by the General Assembly of the State of Indiana:

1 SECTION 1. IC 12-15-35-42 IS AMENDED TO READ AS
2 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 42. (a) The board
3 may meet in an executive session for purposes of reviewing DUR data
4 or to conduct or to discuss activity as provided for in IC 5-14-1.5-6.1.

5 (b) The board shall also conduct regular public meetings to gather
6 input from the public on the operation of the DUR program.

7 **(c) The board may meet monthly to implement its duties under**
8 **this chapter.**

9 SECTION 2. IC 12-15-35-48 IS ADDED TO THE INDIANA
10 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
11 [EFFECTIVE UPON PASSAGE] **Sec. 48. (a) The board shall**
12 **evaluate and make recommendations to the office on disease**
13 **management programs for Medicaid recipients with any of the**
14 **following diseases:**

15 **(1) Asthma.**

16 **(2) Diabetes.**

17 **(3) Congestive heart failure.**

18 **(4) HIV or AIDS.**

EH 1866—LS 7910/DI 98+



C
o
p
y

(b) The board shall:

(1) make the recommendations required under subsection (a);
and

(2) provide a copy of the recommendations to the health
finance commission (IC 2-5-23);
not later than September 30, 2001.

SECTION 3. IC 12-15-35-49 IS ADDED TO THE INDIANA
CODE AS A NEW SECTION TO READ AS FOLLOWS
[EFFECTIVE UPON PASSAGE] Sec. 49. (a) The office shall provide
the board with information necessary for the board to carry out its
advisory capacity.

(b) The office shall provide the information required under
subsection (a):

(1) when requested by the board; and

(2) in a timely manner.

SECTION 4. [EFFECTIVE UPON PASSAGE] The definitions in
405 IAC 1-14.6, as in effect on January 1, 2001, apply throughout
SECTIONS 5 through 6 of this act.

SECTION 5. [EFFECTIVE UPON PASSAGE] (a) Effective July
1, 2001, the cost of professional liability insurance shall be
separated from the administrative rate component and calculated
in a new rate component called "professional liability insurance".
A profit add-on payment may not be added to the calculation of the
professional liability insurance rate component, and there is no
limitation on the amount of the professional liability insurance rate
component in the rate calculation.

(b) Not later than sixty (60) days after the effective date of this
act, each provider shall submit current liability insurance premium
statements and supporting documentation to the state's rate setting
contractor.

(c) The state's rate setting contractor shall:

(1) accept current liability insurance expense information
from providers at any time before July 1, 2004; and

(2) calculate and pay a modified reimbursement rate as
described in subsections (d) through (f).

(d) The professional liability insurance component in the
provider's rate must be equal to the liability insurance expense
from the current liability insurance expense information, including
premium statements and supporting documentation, divided by the
total patient days from the provider's most recently filed cost
report. If the effective date of the policy is earlier than the
sixteenth day of that month, the rate adjustment is effective on the



C
O
P
Y

1 first day of the month. If the effective date of the policy is later
 2 than the fifteenth day of that month, the rate adjustment is
 3 effective on the first day of the month following the month in which
 4 the policy is effective.

5 (e) The cost of professional liability insurance shall be removed
 6 from the administrative component on July 1, 2001, using the
 7 following methodology:

8 STEP ONE: Divide the inflated liability insurance per diem
 9 expense by the allowable administrative per patient day costs.

10 STEP TWO: Multiply the amount calculated under STEP
 11 ONE by the administrative component of the rate.

12 STEP THREE: Subtract the amount calculated under STEP
 13 TWO from the administrative component of the rate.

14 The information needed to perform the calculation under this
 15 subsection shall be obtained from the work papers of the state's
 16 rate setting contractor for the most recent annual rate review for
 17 each facility.

18 (f) The administrative component and professional liability
 19 insurance component are the only two rate components that are
 20 adjusted on July 1, 2001, other than adjustments from routine
 21 annual rate reviews. The median administrative component cost
 22 that excludes the professional liability insurance shall not be
 23 applied for each nursing facility until the facility's first annual rate
 24 review on or after July 1, 2001.

25 (g) After June 30, 2004, the cost of professional liability
 26 insurance shall be included in the administrative rate component,
 27 subject to the profit add-on payment and the limitation on the
 28 administrative rate component. Beginning July 1, 2004, the
 29 calculation of the administrative component of each provider's rate
 30 shall include professional liability insurance in the median
 31 administrative component cost.

32 (h) This SECTION expires July 1, 2004.

33 SECTION 6. [EFFECTIVE UPON PASSAGE] (a) Not later than
 34 June 1, 2002, the office of the secretary of family and social
 35 services established by IC 12-8-1-1 shall adopt rules under
 36 IC 4-22-2 that are effective July 1, 2002, to make the following
 37 Medicaid reimbursement changes to 405 IAC 1-14.6:

38 (1) Physical therapy, speech therapy, occupational therapy,
 39 and respiratory therapy services shall be removed from the
 40 direct care rate component and calculated in a new rate
 41 component called "therapy". A profit add-on payment may
 42 not be added to the calculation of the therapy rate component,



C
o
p
y

and there is no limitation on the amount of the therapy rate component in the rate calculation. The therapy rate component shall be calculated as follows:

STEP ONE: Divide the Medicaid revenue for each therapy service by the total revenue for each therapy service.

STEP TWO: Multiply the amounts determined under STEP ONE for each therapy service by the total cost of each therapy service.

STEP THREE: Add the amounts determined under STEP TWO.

STEP FOUR: Divide the total amount determined under STEP THREE by total Medicaid days.

STEP FIVE: Add the amount determined under STEP FOUR to the rate calculated for the provider.

(2) A provider's indirect care rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for indirect care costs; multiplied by

(B) one hundred ten percent (110%).

(3) A provider's administrative rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for administrative costs; multiplied by

(B) one hundred five percent (105%).

(4) Expenses for repairs and maintenance shall be removed from the capital component and calculated as part of the indirect care component.

(5) A provider's capital rate component shall be limited to the product of:

(A) the average allowable cost of the median patient day for capital costs; multiplied by

(B) ninety percent (90%).

(6) Allowable costs per patient day for capital related costs shall be computed based upon an occupancy level equal to the greater of:

(A) ninety percent (90%); or

(B) the provider's actual occupancy from the most recently completed historical period.

(7) Expenses for property taxes shall be removed from the capital rate component and calculated in new rate component called "property taxes". A profit add-on payment may not be added to the calculation of the property taxes rate component,

C
o
p
y



and there is no limitation on the amount of the property taxes rate component in the rate calculation.

(8) The reimbursement rate for providers having a ventilator patient shall be increased to compensate for the change to the reimbursement rate required by subdivision (1).

(9) The reimbursement rate must be equal to the sum of the following components:

(A) Direct Care.

(B) Indirect Care.

(C) Administrative.

(D) Capital.

(E) Therapy.

(F) Property taxes.

(G) Liability insurance.

(10) The state shall use Resource Utilization Group 5.12, 34 grouper, to determine each resident's case mix index (CMI) that is used to calculate the facility average CMI for all residents and to determine the facility average CMI for Medicaid residents. The CMIs used to calculate the facility average CMI for all residents and to determine the facility average CMI for Medicaid residents shall be as follows:

RUG-III GroupCMI

RAD 2.02

RAC 1.69

RAB 1.50

RAA 1.24

SE3 2.69

SE2 2.23

SE1 1.85

SSC 1.75

SSB 1.60

SSA 1.51

CC2 1.33

CC1 1.27

CB2 1.14

CB1 1.07

CA2 0.95

CA1 0.87

IB2 0.93

IB1 0.82

IA2 0.68

IA1 0.62



C
o
p
y

1	BB2 0.89
2	BB1 0.77
3	BA2 0.67
4	BA1 0.54
5	PE2 1.06
6	PE1 0.96
7	PD2 0.97
8	PD1 0.87
9	PC2 0.83
10	PC1 0.76
11	PB2 0.73
12	PB1 0.66
13	PA2 0.56
14	PA1 0.50

(11) There may not be a phase-in period for implementation of the new reimbursement rates required by this SECTION.

(c) The rules adopted under this SECTION must include the rules adopted under SECTION 7 of this act.

(d) This SECTION expires July 1, 2004.

SECTION 7. [EFFECTIVE UPON PASSAGE] (a) Before July 1, 2001, the office of the secretary of family and social services established by IC 12-8-1-1 shall adopt emergency rules in the same manner that emergency rules are adopted under IC 4-22-2-37.1 to implement SECTION 5 of this act.

(b) An emergency rule adopted under subsection (a) is effective on the later of the following:

(1) July 1, 2001.

(2) The earliest date permitted by federal law.

(c) An emergency rule adopted under subsection (a) expires on the effective date of rules adopted under SECTION 6 of this act.

(d) This SECTION expires July 1, 2004.

SECTION 8. [EFFECTIVE UPON PASSAGE] (a) Not later than September 30, 2001, the office of Medicaid policy and planning established by IC 12-15-1-1 shall submit a state plan amendment to the federal Health Care Financing Administration to implement this act.

(b) This SECTION expires July 1, 2004.

SECTION 9. [EFFECTIVE UPON PASSAGE] (a) The office of the secretary of family and social services established by IC 12-8-1-1 shall recalculate, publish, and pay Medicaid reimbursement rates as modified by this act.

(b) The state's rate setting contractor shall calculate and notify



C
O
P
Y

1 providers of their rates under this act not later than September 1,
2 2001, using the most recent completed cost reports on file as of July
3 1, 2001.

4 (c) This SECTION expires July 1, 2004.

5 SECTION 10. [EFFECTIVE UPON PASSAGE] (a) The office of
6 the secretary of family and social services established by
7 IC 12-8-1-1 may not do any of the following:

8 (1) Repeal 405 IAC 1-14.6.

9 (2) Amend 405 IAC 1-14.6 in any manner that reduces
10 reimbursement for nursing facilities, except as required by
11 SECTION 6(a)(1) of this act, or adopt any other rule under
12 IC 4-22-2 that reduces reimbursement for nursing facilities.

13 (3) Repeal or amend a rule adopted under this act without
14 statutory authority for the repeal or amendment.

15 (b) This SECTION expires July 1, 2004.

16 SECTION 11. [EFFECTIVE UPON PASSAGE] (a) Not later than
17 August 1, 2001, the office of the secretary of family and social
18 services shall identify sources of state or local government funds
19 eligible for federal financial participation under the Medicaid
20 program (42 U.S.C. 1396 et seq.), including sources for
21 intergovernmental transfers from government owned and operated
22 health care entities, including the following:

23 (1) Health facilities.

24 (2) Hospitals.

25 (3) Medical and dental schools.

26 (4) University facilities.

27 (5) Community health centers.

28 (6) Mental health, alcohol, and drug abuse facilities and
29 programs.

30 (7) Mental retardation and developmental disabilities facilities
31 and programs.

32 (8) Psychiatric facilities and programs.

33 (9) Children's facilities and programs.

34 (10) Schools.

35 (11) Any other government owned and operated health
36 related facilities, programs, or services.

37 (b) Not later than August 1, 2001, the office of the secretary of
38 family and social services shall identify sources of state or local
39 government funds that:

40 (1) can be certified as being eligible for federal financial
41 participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR
42 433.51; and

C
o
p
y



(2) are paid to health care entities, including the following:

(A) Health facilities.

(B) Hospitals.

(C) Medical and dental schools.

(D) University facilities.

(E) Community health centers.

(F) Mental health, alcohol, and drug abuse facilities and programs.

(G) Mental retardation and developmental disabilities facilities and programs.

(H) Psychiatric facilities and programs.

(I) Children's facilities and programs.

(J) Schools.

(K) Any other health related facilities, programs, or services.

(c) Not later than August 1, 2001, the office of the secretary of family and social services shall identify the availability of Medicaid disproportionate share payments for state institutions for mental disease for any prior state fiscal year.

(d) Before August 1, 2001, the office of the secretary of family and social services shall identify court ordered health care services that are paid by the state or by local units of government.

(e) Based on the information identified and calculated under subsections (a) through (d), the office of the secretary of family and social services shall, not later than August 1, 2001, do the following:

(1) Develop Medicaid health care coverage programs or health care funding mechanisms. Programs and mechanisms developed under this subdivision may not require the reduction or cessation of current programs using intergovernmental transfers or certification of government funds as the state's share of Medicaid payments.

(2) Submit a state plan amendment to the federal Health Care Financing Administration to apply for approval of the programs or mechanisms developed under subdivision (1).

(f) Before July 1, 2001, the office shall publish public notice in accordance with the regulations of the federal Health Care Financing Administration of the office's intent to implement the programs and mechanisms developed under subsection (e).

(g) This SECTION expires July 1, 2004.

SECTION 12. [EFFECTIVE UPON PASSAGE] (a) Not later than August 1, 2001, the office of the secretary of family and social

C
O
P
Y



services shall do the following:

(1) Identify opportunities for Medicaid waivers or expansions, paid with no new state tax funds, to cover individuals with health care needs.

(2) Identify entities afforded Indiana tax credits on the basis of their payment of taxes or assessments used to directly fund health care services or insurance coverage for individuals who would be eligible for coverage under a Medicaid waiver or expansion identified in subdivision (1).

(3) Calculate increased tax revenues realized by the state through the reduction in Indiana tax credits taken by entities described in subdivision (2) due to the reduction in taxes or assessments paid by the entities resulting from the fact that the health care needs of individual identified in subdivision (2) are covered by Medicaid.

(b) This SECTION expires July 1, 2004.

SECTION 13. [EFFECTIVE UPON PASSAGE] (a) The office of the secretary of family and social services shall, not later than October 1, 2001, file a report with the legislative council regarding the office's activities under this act.

(b) This SECTION expires July 1, 2004.

SECTION 14. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) This section applies to an individual who:

- (1) is a Medicaid recipient;
- (2) is not enrolled in the risk-based managed care program;
- and
- (3) resides in:

(A) a county having a population of more than three hundred thousand (300,000) but less than four hundred thousand (400,000);

(B) a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000); or

(C) a county with a consolidated city.

(c) The office shall develop the following programs regarding individuals described in subsection (b):

(1) A disease management program for recipients with any of the following diseases:

- (A) Asthma.
- (B) Diabetes.



C
O
P
Y

- 1 (C) Congestive heart failure.
- 2 (D) HIV or AIDS.
- 3 (2) A case management program for recipients whose per
- 4 recipient Medicaid cost is in the highest ten percent (10%) of
- 5 all individuals described in subsection (b).
- 6 (d) The office shall contract with an outside individual or entity
- 7 to assist in developing the programs required under subsection (c).
- 8 The office shall begin the contract procurement process not later
- 9 than October 1, 2001.
- 10 (e) The individual or entity with whom the office contracts
- 11 under subsection (c) shall provide the office with an evaluation and
- 12 recommendations not more than nine (9) months after the effective
- 13 date of the contract.
- 14 (f) The office shall report to the legislative council not later than
- 15 December 31, 2002, regarding the programs developed under this
- 16 SECTION.
- 17 SECTION 15. An emergency is declared for this act.

C
o
p
y



COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1866, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 2, line 18, delete "five percent (105%)" and insert **"seven percent (107%)"**.

Page 2, line 37, delete "ninety percent (90%)" and insert **"one hundred percent (100%)"**.

Page 2, delete lines 38 through 42.

Page 3, delete line 1.

Page 3, line 2, delete "(9)" and insert **"(8)"**.

Page 3, line 8, delete "(10)" and insert **"(9)"**.

Page 3, line 14, delete "(11)" and insert **"(10)"**.

Page 3, line 32, delete "days (150)" and insert **"(150) days"**.

Page 3, line 39, delete "(12)" and insert **"(11)"**.

Page 4, line 20, delete "(13)" and insert **"(12)"**.

Page 4, line 23, delete "(14)" and insert **"(13)"**.

Page 4, line 27, delete "(15)" and insert **"(14)"**.

Page 4, line 36, delete "(16)" and insert **"(15)"**.

Page 5, line 36, delete "(17)" and insert **"(16)"**.

Page 5, between lines 38 and 39, begin a new paragraph and insert:
"SECTION 2. [EFFECTIVE UPON PASSAGE] (a) The definitions in this SECTION apply throughout SECTIONS 3 through 8 of this act.

(b) "Bed" refers to a comprehensive care bed.

(c) "Fund" refers to the eldercare trust fund established by this act.

(d) "Health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

(e) "Office" refers to the office of Medicaid policy and planning.

(f) "Patient day" refers to a patient day as reported on:

(1) a health facility's Medicaid cost report if the facility participates in the Medicaid program; or

(2) the form developed by the office under this act if the facility does not participate in the Medicaid program.

(g) This SECTION expires August 1, 2003.

SECTION 3. [EFFECTIVE JULY 1, 2001] (a) The eldercare trust fund is established. The fund consists of the money deposited in the fund from the reimbursement allowance collected under this act.

(b) The expenses of administering the fund shall be paid from money in the fund.

EH 1866—LS 7910/DI 98+



C
o
p
y

(c) Interest that accrues from investing the money in the fund shall be deposited in the fund.

(d) The money in the fund shall be used to pay the state's share of the costs to supplement and enhance reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as required by SECTION 1 of this act.

(e) The money in the fund may not be used to reduce or replace the amount of state money that otherwise is being paid as of July 1, 2001, or that otherwise would be paid after July 1, 2001, if this act had not been enacted to reimburse nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(f) All federal financial participation that is obtained due to the expenditure required by subsection (d) shall be expended to supplement and enhance reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as required by SECTION 1 of this act.

(g) If federal financial participation becomes unavailable to match money from the fund for the purpose of supplementing and enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall cease collection of the reimbursement allowance under this act and refund all of the money remaining in the fund.

(h) This SECTION expires August 1, 2003.

SECTION 4. [EFFECTIVE AUGUST 1, 2001] (a) The office shall collect a reimbursement allowance from each health facility of four dollars and sixty-five cents (\$4.65) for each patient day in the health facility. The office shall deposit the money collected in the eldercare trust fund.

(b) This SECTION expires August 1, 2003.

SECTION 5. [EFFECTIVE JULY 1, 2001] (a) This SECTION applies only to health facilities that participate in the Medicaid program.

(b) The office shall do the following:

- (1) Determine the number of patient days for each health facility for the previous Medicaid cost reporting period.
- (2) Determine the amount of the annual reimbursement allowance for each health facility based upon the number of patient days. The reimbursement allowance shall be adjusted



C
o
p
y

on an annual basis effective the first day of the second calendar quarter following the end of the facility's Medicaid cost reporting year.

(3) Notify each health facility each year not later than thirty (30) days after receipt of the facility's cost report of the amount of the annual reimbursement allowance.

(4) Withhold one-twelfth (1/12) of each health facility's annual reimbursement allowance each month through the Medicaid claims payment system. The annual reimbursement allowance shall be collected against the claims for service dates that coincide with the period that the allowance is in effect.

(c) The reimbursement allowance collected under this act is considered an allowable cost for Medicaid reimbursement purposes in the administrative rate component.

(d) The office may not begin collection of the reimbursement allowance under this act before the office calculates and begins paying new reimbursement rates under SECTION 1 of this act.

(e) This SECTION expires August 1, 2003.

SECTION 6. [EFFECTIVE JULY 1, 2001] (a) This SECTION applies only to health facilities that do not participate in the Medicaid program.

(b) The office shall develop and distribute to each health facility subject to this SECTION a form that will collect the following data:

(1) Total number of beds in the health facility.

(2) Number of patient days during the previous tax reporting period.

(c) Each health facility shall complete and submit the form on an annual basis not later than ninety (90) days after the end of the facility's tax reporting period. The period for this report is equal to the facility's tax reporting period.

(d) The office shall do the following:

(1) Determine the amount of the annual reimbursement allowance for each health facility based upon the number of patient days during the previous tax reporting period. The reimbursement allowance shall be adjusted on an annual basis effective the first day of the second calendar quarter following the end of the facility's tax reporting year.

(2) Notify each health facility each year not later than thirty (30) days after receipt of the facility's form of the amount of the annual reimbursement allowance.

(e) Each facility shall pay one-twelfth (1/12) of the facility's

C
O
P
Y



annual reimbursement allowance to the office not later than the tenth day of each month beginning in August 2001 and ending in July 2003.

(f) This SECTION expires August 1, 2003.

SECTION 7. [EFFECTIVE UPON PASSAGE] (a) This SECTION applies only to health facilities that participate in the Medicaid program.

(b) Before July 1, 2001, the office shall do the following:

- (1) Determine the number of patient days for each health facility for the previous Medicaid cost reporting period.
- (2) Determine the amount of the annual reimbursement allowance for each health facility based upon the number of patient days.
- (3) Notify each health facility of the amount of the annual reimbursement allowance.

(c) This SECTION expires July 1, 2001.

SECTION 8. [EFFECTIVE UPON PASSAGE] (a) This SECTION applies only to health facilities that do not participate in the Medicaid program.

(b) Before June 1, 2001, the office shall develop and distribute to each health facility subject to this SECTION a form that will collect the following data:

- (1) Total number of beds in the health facility.
- (2) Number of patient days during the previous tax reporting period.

(c) Before June 15, 2001, each health facility shall complete and submit the form. The period for this report is equal to the facility's tax reporting period.

(d) Before July 1, 2001, the office shall do the following:

- (1) Determine the amount of the annual reimbursement allowance for each health facility based upon the number of patient days during the previous tax reporting period.
- (2) Notify each health facility of the amount of the annual reimbursement allowance.

(e) This SECTION expires July 1, 2001."

Page 6, line 1, delete "SECTION 1 of".

Page 6, line 7, delete "SECTION 1 of".

Page 6, line 25, after "." insert "The state's rate setting contractor shall include in the calculation of:

- (1) the administrative medians for rate effective dates of July 1, 2001, through September 30, 2002; and
- (2) each provider's reimbursement rates with rate effective

C
O
P
Y



**dates of July 1, 2001, through September 30, 2002;
the initial amount of the reimbursement allowance that the
provider will pay under this act."**

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1866 as introduced.)

BAUER, Chair

Committee Vote: yeas 20, nays 4.

C
o
p
y



HOUSE MOTION

Mr. Speaker: I move that House Bill 1866 be amended to read as follows:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid.

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-131.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY1, 2001]: **Sec. 131.3. "Minimum data set" or "MDS" has the meaning set forth in IC 12-15-41-1.**

SECTION 2. IC 12-15-41 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2001]:

Chapter 41. Annual Review of Medicaid Nursing Facility Residents

Sec. 1. "Minimum data set" or "MDS" means a core set of screening and assessment elements, including common definitions and coding categories, used as:

- (1) a comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program; and**
- (2) a standardized communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies.**

Sec. 2. A nursing facility certified to provide nursing facility care to Medicaid recipients shall submit to the office annually minimum data set (MDS) information for each of its Medicaid residents.

Sec. 3. (a) The office or the office's designated contractor shall evaluate the MDS information submitted for each Medicaid resident. The evaluation must consist of an assessment of the following:

- (1) The individual's medical needs.**
 - (2) The availability of services, other than services provided in a nursing facility, that are appropriate to the individual's needs.**
 - (3) The cost effectiveness of providing services appropriate to the individual's needs that are provided outside of, rather than within, a nursing facility.**
- (b) The assessment must be conducted in accordance with rules**



C
o
p
y

adopted under IC 4-22-2 by the office.

Sec. 4. If the office determines under section 3 of this chapter that an individual's needs could be met in a cost effective manner in a setting other than a nursing facility, the office shall counsel the individual and provide the individual with written notice containing the following:

- (1) The reasons for the office's determination.**
- (2) A detailed description of services available to the individual that, if used by the individual, would make the continued placement of the individual in a nursing facility inappropriate. The detailed description of services available must do the following:**
 - (A) Include a determination of whether the provider of the services available actually has the capacity to provide the services.**
 - (B) State the name of the provider of the services.**
 - (C) Designate the specific site at which the services are available.**

Sec. 5. If an individual appeals a discharge from a nursing facility under this chapter, the office shall continue payment to the nursing facility until the individual has exhausted the appeal process."

Page 5, line 34, delete "3 through 8" and insert **"5 through 10"**.

Page 6, line 17, delete "1" and insert **"3"**.

Page 6, line 28, delete "1" and insert **"3"**.

Page 7, line 27, delete "1" and insert **"3"**.

Page 10, line 5, delete "1(b)(1)" and insert **"3(b)(1)"**.

Renumber all SECTIONS consecutively.

(Reference is to HB 1866 as printed February 27, 2001.)

CRAWFORD

HOUSE MOTION

Mr. Speaker: I move that House Bill 1866 be amended to read as follows:

Page 2, line 18, delete "seven percent (107%)" and insert **"six percent (106%)"**.

Page 5, between lines 31 and 32, begin a new line blocked left and insert:

"Rules adopted under this SECTION expire July 1, 2003.

EH 1866—LS 7910/DI 98+



C
O
P
Y

Reimbursement rates under this SECTION apply only before July 1, 2003. The office may not adopt rules that change the reimbursement percentages specified in this SECTION. After June 30, 2003, the rules concerning reimbursement that were in effect before the changes under this SECTION shall apply."

Page 6, line 18, delete "not" and insert "only".

Page 6, line 18, delete "to reduce or replace".

Page 6, delete lines 19 through 20.

Page 6, line 21, delete "act had not been enacted to reimburse nursing facilities".

Page 6, run in lines 18 and 21.

Page 6, line 25, delete "to".

Page 6, line 26, delete "supplement and enhance reimbursement to nursing facilities".

Page 6, line 39, delete "four" and insert "five".

Page 6, line 40, delete "and sixty-five cents (\$4.65)" and insert "\$5".

Page 9, line 20, delete "However, approval of the state plan amendment by the".

Page 9, delete lines 21 through 23.

Page 10, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 13. [EFFECTIVE JULY 1, 2001] (a) As used in this SECTION, "health facility" refers to a health facility that is licensed under IC 16-28 as a comprehensive care facility.

(b) As used in this SECTION, "qualifying individual" means an individual who receives qualifying services during the period beginning July 1, 2001, and ending June 30, 2003.

(c) As used in this SECTION, "qualifying services" means routine per diem services received in a health facility on a twenty-four (24) hour basis that were not paid for entirely or in part under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.), under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), or under a federal Department of Veterans Affairs program for veterans.

(d) A qualifying individual is entitled to a tax credit against the individual's adjusted gross income tax liability. The amount of the tax credit that each qualifying individual may claim on the individual's state tax return is equal to one hundred fifty dollars (\$150) for each thirty (30) days that the qualifying individual receives qualifying services.

(e) Not more than one (1) credit is allowed under this SECTION for each qualifying individual.



C
O
P
Y

(f) To obtain a credit under this SECTION, a taxpayer must claim the credit on the taxpayer's annual state tax return or returns in the manner prescribed by the department of state revenue. The taxpayer shall submit to the department of state revenue all information that the department of state revenue determines is necessary for the calculation of the credit provided by this SECTION.

(g) Each health facility shall provide the data requested by the department of state revenue on qualifying individuals that is necessary to implement this SECTION.

(h) If the credit amount under subsection (d) exceeds the taxpayer's adjusted gross income tax liability for the taxable year, the excess shall be refunded to the taxpayer.

(i) This SECTION expires July 1, 2003."

Renumber all SECTIONS consecutively.

(Reference is to HB 1866 as printed February 27, 2001.)

CRAWFORD

C
o
p
y



COMMITTEE REPORT

Mr. President: The Senate Committee on Finance, to which was referred House Bill No. 1866, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 18, begin a new paragraph and insert:

"SECTION 1. IC 12-15-35-48 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE] **Sec. 48. (a) The board shall evaluate and make recommendations to the office on programs or initiatives that can be utilized by the office or through a contractor to reduce costs in the Medicaid outpatient and institutional prescription drug programs.**

(b) In providing its recommendations to the office, the board shall also evaluate whether the programs or initiatives will:

(1) increase other Medicaid costs, including:

- (A) physician services;**
- (B) hospital services;**
- (C) nursing home services; and**
- (D) laboratory services; or**

(2) result in poorer health outcomes for Medicaid recipients.

(c) The board shall conduct an audit of the Medicaid outpatient and institutional prescription drug programs for state fiscal years 1999, 2000, and 2001, to determine if any claims for prescription drugs that were reimbursed by Medicaid were claims that were fraudulently billed. The board shall report the audit findings to the office, the select joint commission on Medicaid oversight, and the attorney general by September 1, 2001, and on a quarterly basis after that date.

(d) Beginning September 1, 2001, the board shall conduct an ongoing audit of the Medicaid outpatient and institutional prescription drug programs to determine if any claims for prescription drugs that were reimbursed by Medicaid were claims that were fraudulently billed. The board shall report the audit findings to the office, the select joint commission on Medicaid oversight, and the attorney general after the close of each state fiscal quarter.

SECTION 2. IC 12-15-35-49 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE] **Sec. 49. (a) The office shall provide the board with information necessary for the board to carry out its duties under this chapter, including the audits required under**

C
o
p
y



section 48 of this chapter.

(b) The office shall provide the information required under subsection (a):

(1) when requested by the board; and

(2) in a timely manner."

Page 2, delete lines 1 through 38.

Page 2, line 39, delete "(a)".

Page 2, line 41, delete "this SECTION." and insert "SECTIONS 4 through 5 of this act.

SECTION 4. [EFFECTIVE JULY 1, 2001] (a) The cost of professional liability insurance shall be separated from the administrative rate component and calculated in a new rate component called "professional liability insurance". A profit add-on payment may not be added to the calculation of the professional liability insurance rate component, and there is no limitation on the amount of the professional liability insurance rate component in the rate calculation. Each provider shall submit current liability insurance premium statements and supporting documentation to the state's rate setting contractor. The professional liability insurance component in the provider's rate must be equal to the liability insurance expense from the current liability premium statements and supporting documentation divided by the total patient days from the provider's most recently filed cost report. The rate adjustment is effective on the first day of the month, if the effective date of the policy is between the first and fifteenth day of that month. If the effective date of the policy is between the sixteenth and last day of that month, the rate adjustment is effective on the first day of the following month. After June 30, 2004, the cost of professional liability insurance must be included in the administrative rate component, subject to the profit add-on payment and the limitation on the administrative rate component.

(b) This SECTION expires July 1, 2004."

Page 2, line 42, delete "(b)" and insert "SECTION 5. [EFFECTIVE UPON PASSAGE] (a)".

Page 2, line 42, delete "January" and insert "July".

Page 3, line 32, delete "six" and insert "five".

Page 3, line 32, delete "(106%)" and insert "(105%)".

Page 3, delete lines 36 through 42.

Page 4, delete lines 1 through 4.

Page 4, line 5, delete "(7)" and insert "(5)".

Page 4, line 9, delete "one hundred" and insert "ninety".

C
O
P
Y



Page 4, line 9, delete "(100%)" and insert "**(90%)**".
 Page 4, line 10, delete "(8)" and insert "**(6)**".
 Page 4, line 13, delete "eighty-five" and insert "**ninety**".
 Page 4, line 13, delete "(85%)" and insert "**(90%)**".
 Page 4, line 16, delete "(9)" and insert "**(7)**".
 Page 4, delete lines 22 through 42.
 Page 5, delete lines 1 through 27.
 Page 5, line 28, delete "(12)" and insert "**(8)**".
 Page 5, delete lines 31 through 34.
 Page 5, line 35, delete "(14)" and insert "**(9)**".
 Page 6, line 2, delete "(15)" and insert "**(10)**".
 Page 7, line 2, delete "(16)" and insert "**(11)**".
 Page 7, delete lines 4 through 9.
 Page 7, line 10, delete "2003." and insert "**2004.**".
 Page 7, delete lines 11 through 42.
 Delete pages 8 through 9.
 Page 10, delete lines 1 through 18.
 Page 10, line 23, after "implement" insert "**SECTION 2 of**".
 Page 10, line 30, delete "2003." and insert "**2004.**".
 Page 10, line 36, delete "2003." and insert "**2004.**".
 Page 11, line 2, delete "The state's rate setting contractor shall include in the".
 Page 11, delete lines 3 through 9.
 Page 11, line 10, delete "2003." and insert "**2004.**".
 Page 11, line 17, delete "3(b)(1)" and insert "**3(a)(1)**".
 Page 11, line 21, delete "2003." and insert "**2004.**".
 Page 11, delete lines 22 through 42.
 Page 12, delete lines 1 through 14, begin a new paragraph and insert:
 "SECTION 10. [EFFECTIVE UPON PASSAGE] **(a) Not later than August 1, 2001, the office of the secretary of family and social services shall identify voluntary sources of state or local government funds eligible for federal financial participation under the Medicaid program (42 U.S.C. 1396 et seq.), including sources for intergovernmental transfers from government owned and operated health care entities, including the following:**
 (1) Health facilities.
 (2) Hospitals.
 (3) Medical and dental schools.
 (4) University facilities.
 (5) Community health centers.
 (6) Mental health, alcohol, and drug abuse facilities and



programs.

(7) Mental retardation and developmental disabilities facilities and programs.

(8) Psychiatric facilities and programs.

(9) Children's facilities and programs.

(10) Schools.

(11) Any other government owned and operated health related facilities, programs, or services.

(b) Not later than August 1, 2001, the office of the secretary of family and social services shall identify voluntary sources of state or local government funds that:

(1) can be certified as being eligible for federal financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51; and

(2) are paid to health care entities, including the following:

(A) Health facilities.

(B) Hospitals.

(C) Medical and dental schools.

(D) University facilities.

(E) Community health centers.

(F) Mental health, alcohol, and drug abuse facilities and programs.

(G) Mental retardation and developmental disabilities facilities and programs.

(H) Psychiatric facilities and programs.

(I) Children's facilities and programs.

(J) Schools.

(K) Any other health related facilities, programs, or services.

(c) Not later than August 1, 2001, the office of the secretary of family and social services shall identify the availability of Medicaid disproportionate share payments for state institutions for mental disease for any prior state fiscal year.

(d) Before August 1, 2001, the office of the secretary of family and social services shall identify court ordered health care services that are paid by the state or by local units of government.

(e) Based on the information identified and calculated under subsections (a) through (d), the office of the secretary of family and social services shall, not later than August 1, 2001, do the following:

(1) Develop Medicaid health care coverage programs or health care funding mechanisms. Programs and mechanisms

C
o
p
y



developed under this subdivision may not require the reduction or cessation of current programs using intergovernmental transfers or certification of government funds as the state's share of Medicaid payments.

(2) Apply to the federal Health Care Financing Administration for approval of the programs or mechanisms developed under subdivision (1).

(f) This SECTION expires July 1, 2004.

SECTION 11. [EFFECTIVE UPON PASSAGE] (a) Not later than August 1, 2001, the office of the secretary of family and social services shall do the following:

(1) Identify opportunities for Medicaid waivers or expansions, paid with no new state tax funds, to cover individuals with health care needs.

(2) Identify entities afforded Indiana tax credits on the basis of their payment of taxes or assessments used to directly fund health care services or insurance coverage for individuals who would be eligible for coverage under a Medicaid waiver or expansion identified in subdivision (1).

(3) Calculate increased tax revenues realized by the state through the reduction in Indiana tax credits taken by entities described in subdivision (2) due to the reduction in taxes or assessments paid by the entities resulting from the fact that the health care needs of individual identified in subdivision (2) are covered by Medicaid.

(b) This SECTION expires July 1, 2004.

SECTION 12. [EFFECTIVE UPON PASSAGE] (a) The office of the secretary of family and social services shall, not later than October 1, 2001, file a report with the legislative council regarding the office's activities under this act.

(b) This SECTION expires July 1, 2004."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1866 as reprinted March 6, 2001.)

BORST, Chairperson

Committee Vote: Yeas 13, Nays 2.



C
o
p
y

SENATE MOTION

Mr. President: I move that Engrossed House Bill 1866 be amended to read as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-15-35-42 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 42. (a) The board may meet in an executive session for purposes of reviewing DUR data or to conduct or to discuss activity as provided for in IC 5-14-1.5-6.1.

(b) The board shall also conduct regular public meetings to gather input from the public on the operation of the DUR program.

(c) The board may meet monthly to implement its duties under this chapter."

Page 1, line 4, after "on" insert "**disease management**".

Page 1, line 4, delete "or" and insert "**for Medicaid recipients with any of the following diseases:**

(1) Asthma.

(2) Diabetes.

(3) Congestive heart failure.

(4) HIV or AIDS."

Page 1, delete lines 5 through 18, begin a new paragraph and insert:

"(b) The board shall:

(1) make the recommendations required under subsection (a); and

(2) provide a copy of the recommendations to the health finance commission (IC 2-5-23);

not later than September 30, 2001."

Page 2, delete lines 1 through 13.

Page 2, line 17, after "its" insert "**advisory capacity**".

Page 2, delete lines 18 through 19.

Page 2, line 26, delete "4" and insert "**5**".

Page 2, line 26, delete "5" and insert "**6**".

Page 2, line 27, delete "JULY 1, 2001" and insert "**UPON PASSAGE**".

Page 2, line 27, delete "The" and insert "**Effective July 1, 2001, the**".

Page 2, line 34, delete "Each", begin a new paragraph, and insert:

"(b) Not later than sixty (60) days after the effective date of this act, each".

Page 2, line 36, after "." begin a new paragraph and insert:

"(c) The state's rate setting contractor shall:

(1) accept current liability insurance expense information

EH 1866—LS 7910/DI 98+



C
O
P
Y

from providers at any time before July 1, 2004; and
 (2) calculate and pay a modified reimbursement rate as described in subsections (d) through (f).

(d)".

Page 2, line 39, after "liability" insert **"insurance expense information, including"**.

Page 2, line 39, after "documentation" insert ",".

Page 2, line 41, delete "The" and insert **"If the effective date of the policy is earlier than the sixteenth day of that month, the"**.

Page 2, line 42, delete "month, if the effective date of the policy is between the first" and insert **"month. If the effective date of the policy is later than the fifteenth day of that month, the rate adjustment is effective on the first day of the month following the month in which the policy is effective."**

Page 3, delete lines 1 through 3, begin a new paragraph and insert:
"(e) The cost of professional liability insurance shall be removed from the administrative component on July 1, 2001, using the following methodology:

STEP ONE: Divide the inflated liability insurance per diem expense by the allowable administrative per patient day costs.

STEP TWO: Multiply the amount calculated under STEP ONE by the administrative component of the rate.

STEP THREE: Subtract the amount calculated under STEP TWO from the administrative component of the rate.

The information needed to perform the calculation under this subsection shall be obtained from the work papers of the state's rate setting contractor for the most recent annual rate review for each facility.

(f) The administrative component and professional liability insurance component are the only two rate components that are adjusted on July 1, 2001, other than adjustments from routine annual rate reviews. The median administrative component cost that excludes the professional liability insurance shall not be applied for each nursing facility until the facility's first annual rate review on or after July 1, 2001.

(g)".

Page 3, line 5, delete "must" and insert **"shall"**.

Page 3, line 7, after "." insert **"Beginning July 1, 2004, the calculation of the administrative component of each provider's rate shall include professional liability insurance in the median administrative component cost."**

Page 3, line 8, delete "(b)" and insert **"(h)"**.



C
O
P
Y

Page 3, line 10, delete "July" and insert "June".

Page 3, line 11, after "IC 4-22-2" insert **"that are effective July 1, 2002,"**.

Page 5, between lines 34 and 35, begin a new paragraph and insert:

"(c) The rules adopted under this SECTION must include the rules adopted under SECTION 7 of this act."

Page 5, line 35, delete "(c)" and insert "(d)".

Page 5, line 40, delete "2" and insert "5".

Page 6, line 4, after "under" insert **"SECTION 6 of"**.

Page 6, line 27, delete "3(a)(1)" and insert **"6(a)(1)"**.

Page 6, line 34, delete "voluntary".

Page 7, line 12, delete "voluntary".

Page 8, line 7, delete "Apply" and insert **"Submit a state plan amendment"**.

Page 8, line 8, after "Administration" insert **"to apply"**.

Page 8, between lines 9 and 10, begin a new paragraph and insert:

"(f) Before July 1, 2001, the office shall publish public notice in accordance with the regulations of the federal Health Care Financing Administration of the office's intent to implement the programs and mechanisms developed under subsection (e)."

Page 8, line 10, delete "(f)" and insert "(g)".

Page 8, between lines 33 and 34, begin a new paragraph and insert:

"SECTION 14. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) This section applies to an individual who:

(1) is a Medicaid recipient;

(2) is not enrolled in the risk-based managed care program; and

(3) resides in:

(A) a county having a population of more than three hundred thousand (300,000) but less than four hundred thousand (400,000);

(B) a county having a population of more than four hundred thousand (400,000) but less than seven hundred thousand (700,000); or

(C) a county with a consolidated city.

(c) The office shall develop the following programs regarding individuals described in subsection (b):

(1) A disease management program for recipients with any of the following diseases:

(A) Asthma.

C
O
P
Y



(B) Diabetes.

(C) Congestive heart failure.

(D) HIV or AIDS.

(2) A case management program for recipients whose per recipient Medicaid cost is in the highest ten percent (10%) of all individuals described in subsection (b).

(d) The office shall contract with an outside individual or entity to assist in developing the programs required under subsection (c). The office shall begin the contract procurement process not later than October 1, 2001.

(e) The individual or entity with whom the office contracts under subsection (c) shall provide the office with an evaluation and recommendations not more than nine (9) months after the effective date of the contract.

(f) The office shall report to the legislative council not later than December 31, 2002, regarding the programs developed under this SECTION."

Renumber all SECTIONS consecutively.

(Reference is to EHB 1866 as printed March 30, 2001.)

MILLER

C
o
p
y

